5. Diagnosis and Management of RTIs/STIs

A simplified tool (flowchart) will help to guide health workers in the management of RTIs/STIs. The flowcharts describe the clinical syndrome, specific RTIs/STIs under the syndrome and the causative organisms of the RTI/STI syndrome. Differential diagnosis of the conditions is also mentioned wherever appropriate. The approach to the lient with specific points to be considered during history taking and examination is highlighted. If facilities and skills are available, the laboratory tests which need to be done are also mentioned. The treatment protocols to be followed at the primary health care system with appropriate referrals where indicated is also given. Special emphasis is given on syndrome specific partner management and management issues specific to pregnancy.

Box 5.1 Important considerations for management of all clients of RTIs/STIs

Important considerations for management of all clients of RTIs/STIs

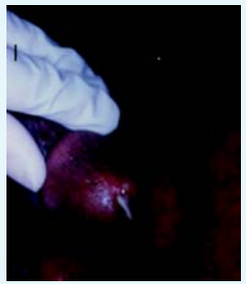
- Educate and counsel client and sex partner(s) regarding RTIs/STIs, genital cancers, safer sex practices and importance of taking complete treatment
- Treat partner(s) where ever indicated
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate about correct and consistent use
- Refer for voluntary counseling and testing for HIV, Syphilis and Hepatitis B
- Consider immunization against Hepatitis B
- Schedule return visit after 7 days to ensure treatment compliance as well as to see reports of tests done.
- If symptoms persist, assess whether it is due to treatment failure or re-infection and advise prompt referral.

FLOWCHARTS

Flowcharts for Management of RTI/STI Syndromes

Flowchart 5.1 : Management of Urethral Discharge/Burning Micturition in Males

SYNDROME: URETHRAL DISCHARGE IN MALES



RTIs/STIs: GONORRHEA, CHLAMYDIAL INFECTION, TRICHOMONIASIS

Causative Organisms
- *Neisseria gonorrhoeae*
- *Chlamydia trachomatis*
- *Trichomonas vaginalis*

History of
- Urethral discharge
- Pain or burning while passing urine, increased frequency of urination
- Sexual exposure of either partner to high risk practices including oro-genital sex

Examination
Look for
- The urethral meatus for redness and swelling
- If urethral discharge is not seen, then gently massage the urethra from the ventral part of the penis towards the meatus and look for thick, creamy greenish-yellow or mucoid discharge

Laboratory Investigations (if available)
- Gram stain examination of the urethral smear will show gram-negative intracellular diplococci in case of gonorrhea,
- In non-gonococcal urethritis more than 5 neutrophils per oil immersion field (1000X) in the urethral smear or more than 10 neutrophils per high power field in the sediment of the first void urine are observed

Treatment

As dual infection is common, the treatment for urethral discharge should adequately cover therapy for both, gonorrhea and chlamydial infections.

Recommended regimen for uncomplicated gonorrhea + chlamydia

Uncomplicated infections indicate that the disease is limited to the anogenital region (anterior urethritis and proctitis).

- Tab. Cefixime 400 mg orally, single dose Plus

Tab Azithromycin 1 gram orally single dose under supervision

- Advise the client to return after 7 days of start of therapy

When symptoms persist or recur after adequate treatment for gonorrhea and chlamydia in the index client and partner(s), they should be treated for *Trichomonas vaginalis.*

If discharge or only dysuria persists after 7 days

- Tab. Secnidazole 2gm orally, single dose (to treat for *T. vaginalis*)

If the symptoms still persists

- Refer to higher centre as early as possible

If individuals are allergic to Azithromycin, give Erythromycin 500 mg four times a day for 7 days

Syndrome specific guidelines for partner management

- Treat all recent partners
- Treat female partners (for gonorrhea and chlamydia) on same lines after ruling out pregnancy and history of allergies
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate about correct and consistent use
- Refer for voluntary counseling and testing for HIV, Syphilis and Hepatitis B
- Schedule return visit after 7 days

Follow up

After seven days

- To see reports of tests done for HIV, syphilis and Hepatitis B
- If symptoms persist, to assess whether it is due to treatment failure or re-infection
- For prompt referral if required

Management of pregnant partner

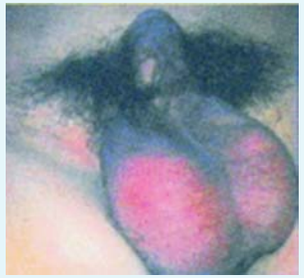
Pregnant partners of male clients with urethral discharge should be examined by doing a per speculum as well as per vaginal examination and should be treated for gonococcal as well as chlamydial infections.

- Cephalosporins to cover gonococcal infection are safe and effective in pregnancy
  - Tab. Cefixime 400mg orally, single dose or
  - Ceftriaxone 125mg by intramuscular injection
    +
  - Tab. Erythromycin 500mg orally four times a day for seven days or
  - Cap Amoxicillin 500mg orally, three times a day for seven days to cover chlamydial infection

- Quinolones (like ofloxacin, ciprofloxacin), doxycycline are contraindicated in pregnant women.

Flowchart 5.2: Management of Scrotal Swelling

SYNDROME: SCROTAL SWELLING



RTIs/STIs : GONORRHEA, CHLAMYDIAL INFECTION

Causative Organisms
- *Neisseria gonorrhoeae*
- *Chlamydia trachomatis*

History of
- Swelling and pain in scrotal region
- Pain or burning while passing urine
- Systemic symptoms like malaise, fever
- Sexual exposure including high risk practices like oro-genital sex

Examination
Look for
- Scrotal swelling
- Redness and edema of the overlying skin
- Tenderness of the epididymis and vas deferens
- Associated urethral discharge/genital ulcer/inguinal lymph nodes and if present refer to the respective flowchart
- A transillumination test to rule out hydrocoele should be done.

Laboratory Investigations
(If available)
- Gram stain examination of the urethral smear will show gram-negative intracellular diplococci in case of complicated gonococcal infection
- In non-gonococcal urethritis more than 5 neutrophils per oil immersion field in the urethral smear or more than 10 neutrophils per high power field in the sediment of the first void urine are observed

Differential diagnosis (non RTIs/STIs)

Infections causing scrotal swelling:
Tuberculosis, filariasis, coliforms, pseudomonas, mumps virus infection.

Non infectious causes:
Trauma, Hernia, Hydrocoele, Testicular torsion, and Testicular tumors

Treatment

- Treat for both gonococcal and chlamydial infections
  Tab Cefixime 400 mg orally BD for 7 days Plus
  Cap. Doxycycline 100mg orally, twice daily for 14 days and refer to higher centre as early as possible since complicated gonococcal infection needs parental and longer duration of treatment
- Supportive therapy to reduce pain (bed rest, scrotal elevation with T-bandage and analgesics)

Note

If quick and effective therapy is not given, damage and scarring of testicular tissues may result causing sub fertility

Syndrome specific guidelines for partner management

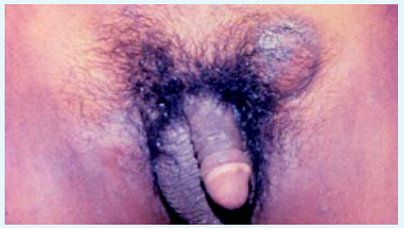
Partner needs to be treated depending on the clinical findings

Management protocol in case the partner is pregnant

- Depending on the clinical findings in the pregnant partner (whether vaginal discharge or endocervical discharge or PID is present) the drug regimens should be used.
- Doxycycline is contraindicated in pregnancy
- Erythromycin base/Amoxicillin can be used in pregnancy.

(Erythromycin estolate is contraindicated in pregnancy due to hepatotoxicity. Erythromycin base or erythromycin ethyl succinate should be given)

SYNDROME: INGUINAL BUBO



RTIs/STIs: LGV, CHANCROID
Causative Organisms

- *Chlamydia trachomatis* serovars *L1, L2, L3*, causative agent of lympho granuloma venerum (LGV)
- *Haemophilus ducreyi* causative agent of chancroid

History
- Swelling in inguinal region which may be painful
- Preceding history of genital ulcer or discharge
- Sexual exposure of either partner including high risk practices like oro-genital sex etc
- Systemic symptoms like malaise, fever

Examination
Look for
- Localized enlargement of lymph nodes in groin which may be tender and fluctuant
- Inflammation of skin over the swelling
- Presence of multiple sinuses
- Edema of genitals and lower limbs
- Presence of genital ulcer or urethral discharge and if present refer to respective flowchart

Laboratory Investigations
Diagnosis is on clinical grounds

Differential diagnosis
- Mycobacterium tuberculosis, filariasis
- Any acute infection of skin of pubic area, genitals, buttocks, anus and lower limbs can also cause inguinal swelling

If malignancy or tuberculosis is suspected refer to higher centre for biopsy.

Treatment

- Start Cap. Doxycycline 100mg orally twice daily for 21 days (to cover LGV)
  Plus
- Tab Azithromycin 1g orally single dose OR
- Tab. Ciprofloxacin 500mg orally, twice a day for three days to cover chancroid
- Refer to higher centre as early as possible.

Note:

- *A bubo should never be incised and drained at the primary health centre, even if it is fluctuant, as there is a high risk of a fistula formation and chronicity. If bubo becomes fluctuant always refer for aspiration to higher centre.*
- *In severe cases with vulval edema in females, surgical intervention may be required for which they should be referred to higher centre.*

Syndrome specific guidelines for partner management

- Treat all partners who are in contact with client in last 3 months
- Partners should be treated for chancroid and LGV
- Tab Azithromycin 1g orally single dose to cover chancroid

+

Cap Doxycycline 100mg orally, twice daily for 21 days to cover LGV

- Advise sexual abstinence during the course of treatment
- Provide condoms, educate on correct and consistent use
- Refer for voluntary counseling and testing for HIV, syphilis and Hepatitis B
- Schedule return visit after 7 days and 21 days

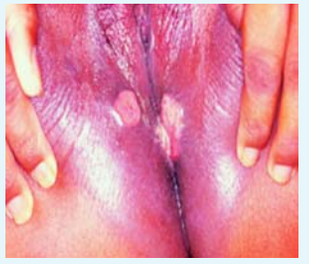
Management of pregnant partner

- Quinolones (like ofloxacin, ciprofloxacin), doxycycline, sulfonamides are contraindicated in pregnant women.
- Pregnant and lactating women should be treated with the erythromycin regimen, and consideration should be given to the addition of a parenteral amino glycoside (e.g., gentamicin)

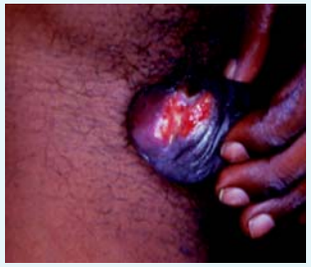
Tab. Erythromycin base, 500mg orally, 4 times daily for 21 days and refer to higher centre.

(Erythromycin estolate is contraindicated in pregnancy due to hepatotoxicity. Erythromycin base or erythromycin ethyl succinate should be given)

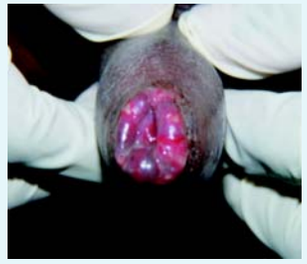
Flowchart 5.4: Management of Genital Ulcers



RTIs/STIs: SYPHILIS



CHANCROID



GENITAL HERPES

Causative Organisms
- *Treponema pallidum* (syphilis)
- *Haemophilus ducreyi* (chancroid)
- *Klebsiella granulomatis* (granuloma inguinale)
- *Chlamydia trachomatis* (lymphogranuloma venerum)
- *Herpes simplex* (genital herpes)

History
- Genital ulcer/vesicles
- Burning sensation in the genital region
- Sexual exposure of either partner to high risk practices including oro-genital sex

Examination
- Presence of vesicles
- Presence of genital ulcer- single or multiple
- Associated inguinal lymph node swelling and if present refer to respective flowchart

Ulcer characteristics:
- Painful vesicles/ulcers, single or multiple - Herpes simplex
- Painless ulcer with shotty lymph node - Syphilis
- Painless ulcer with inguinal lymph nodes - Granuloma inguinale and LGV
- Painful ulcer usually single sometimes associated with painful bubo - Chancroid

Laboratory Investigations
- RPR test for syphilis
- For further investigations refer to higher centre

Treatment

- If vesicles or multiple painful ulcers are present treat for herpes with Tab. Acyclovir 400mg orally, three times a day for 7 days
- If vesicles are not seen and only ulcer is seen, treat for syphilis and chancroid and counsel on herpes genitalis

To cover syphilis give

Inj Benzathine penicillin 2.4 million IU IM after test dose in two divided doses (with emergency tray ready)

(In individuals allergic or intolerant to penicillin, Doxycycline 100mg orally, twice daily for 14 days)

+

Tab Azithromycin 1g orally single dose or

Tab. Ciprofloxacin 500mg orally, twice a day for three days to cover chancroid

Treatment should be extended beyond 7 days if ulcers have not epithelialized i.e. formed a new layer of skin over the sore)

Refer to higher centre

- If not responding to treatment
- Genital ulcers co-existent with HIV
- Recurrent lesion

Syndrome specific guidelines for partner management

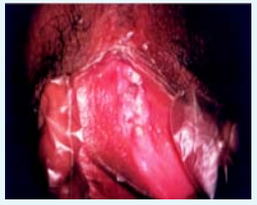
- Treat all partners who are in contact with client in last 3 months
- Partners should be treated for syphilis and chancroid
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate about correct and consistent use
- Refer for voluntary counseling and testing for HIV, Syphilis and Hepatitis B
- Schedule return visit after 7 days

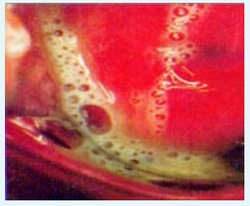
Management of Pregnant Women

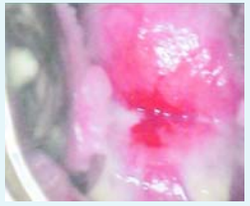
- Quinolones (like ofloxacin, ciprofloxacin), doxycycline, sulfonamides are contraindicated in pregnant women.
- Pregnant women who test positive for RPR should be considered infected unless adequate treatment is documented in the medical records and sequential serologic antibody titers have declined.
- Inj Benzathine penicillin 2.4 million IU IM after test dose (with emergency tray ready)
- A second dose of benzathine penicillin 2.4 million units IM should be administered 1 week after the initial dose for women who have primary, secondary, or early latent syphilis.
- Pregnant women who are allergic to penicillin should be treated with erythromycin and the neonate should be treated for syphilis after delivery.
- Tab. Erythromycin 500mg orally four times a day for 15 days
- (Note: Erythromycin estolate is contraindicated in pregnancy because of drug related hepatotoxicity. Only Erythromycin base or erythromycin ethyl succinate should be used in pregnancy)
- All pregnant women should be asked history of genital herpes and examined carefully for herpetic lesions.
- Women without symptoms or signs of genital herpes or its prodrome can deliver vaginally.
- Women with genital herpetic lesions at the onset of labour should be delivered by caesarean section to prevent neonatal herpes.
- Acyclovir may be administered orally to pregnant women with first episode genital herpes or severe recurrent herpes.

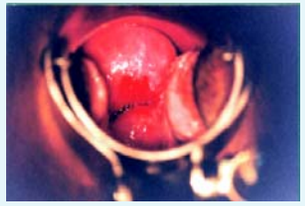
Flowchart 5.5: Management of Vaginal Discharge in Females

SYNDROME: VAGINAL DISCHARGE


VAGINITIS


TRICHOMONIASIS


CERVICAL HERPES


CERVICITIS

Causative Organisms
Vaginitis
- *Trichomonas vaginalis* (TV)
- *Candida albicans*
- *Gardnerella vaginalis, Mycoplasma* causing bacterial vaginosis (BV)

Causative Organisms
Cervicitis
- *Neisseria Gonorrheae*
- *Chlamydia trachomatis*
- *Trichomonas vaginalis*
- *Herpes simplex virus*

History
- Menstrual history to rule out pregnancy
- Nature and type of discharge (amount, smell, color, consistency)
- Genital itching
- Burning while passing urine, increased frequency
- Presence of any ulcer, swelling on the vulval or inguinal region
- Genital complaints in sexual partners
- Low backache

Examination
- Per speculum examination to differentiate between vaginitis and cervicitis.
  a) Vaginitis:
  Trichomoniasis - greenish frothy discharge
  Candidiasis - curdy white discharge
  Bacterial vaginosis – adherent discharge
  Mixed infections may present with atypical discharge
  b) Cervicitis:
  Cervical erosion /cervical ulcer/ mucopurulent cervical discharge
- Bimanual pelvic examination to rule out pelvic inflammatory disease
- If Speculum examination is not possible or client is hesitant treat both for vaginitis and cervicitis

Laboratory Investigations (if available)
- Wet mount microscopy of the discharge for Trichomonas vaginalis and clue cells
- 10% KOH preparation for Candida albicans
- Gram stain of vaginal smear for clue cells seen in bacterial vaginosis
- Gram stain of endocervical smear to detect gonococci

Treatment
Vaginitis (TV+BV+Candida)

- Tab. Secnidazole 2gm orally, single dose or
  Tab. Tinidazole 500mg orally, twice daily for 5 days
- Tab. Metoclopropramide taken 30 minutes before Tab. Secnidazole, to prevent gastric intolerance
- Treat for candidiasis with Tab Fluconazole 150mg orally single dose or local Clotrimazole 500mg vaginal pessaries once

Treatment for cervical infection (chlamydia and gonorrhea)

- Tab cefixim 400 mg orally, single dose
- Plus Azithromnycin 1 gram, 1 hour before lunch. If vomiting within 1 hour, give anti-emetic and repeat

  - If vaginitis and cervicitis are present treat for both
  - Instruct client to avoid douching
  - Pregnancy, diabetes, HIV may also be influencing factors and should be considered in recurrent infections
  - Follow-up after one week

Management in pregnant women
Per speculum examination should be done to rule out pregnancy complications like abortion, premature rupture of membranes
Treatment for vaginitis (TV+BV+Candida)
In first trimester of pregnancy

- Local treatment with Clotrimazole vaginal pessary/cream only for candidiasis. Oral Flucanozole is contraindicated in pregnancy.
- Metronidazole pessaries or cream intravaginally if trichomoniasis or BV is suspected.

In second and third trimester oral metronidazole can be given

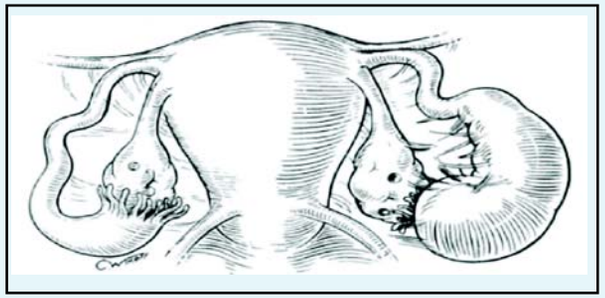
- Tab. Secnidazole 2gm orally, single dose or
- Tab. Metoclopropramide taken 30 minutes before Tab. Metronidazole, to prevent gastric intolerance

Specific guidelines for partner management

- Treat current partner only if no improvement after initial treatment
- If partner is symptomatic, treat client and partner using above protocols
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate about correct and consistent use
- Schedule return visit after 7 days

Flowchart 5.6: Management of Lower Abdominal Pain in Females

SYNDROME: LOWER ABDOMINAL PAIN



Pelvic inflammatory disease

Causative Organisms
- *Neisseria gonorrheae*
- *Chlamydia trachomatis*
- *Mycoplasma,Gardnerella,* Anaerobic bacteria (Bacteroides sp,gram positive cocci)

History
- Lower abdominal pain
- Fever
- Vaginal discharge
- Menstrual irregularities like heavy, irregular vaginal bleeding
- Dysmenorrhoea
- Dyspareunia
- Dysuria, tenesmus
- Low backache
- Contraceptive use like IUD

Examination
- General examination: temperature, pulse, blood pressure
- Per speculum examination: vaginal/cervical discharge, congestion or ulcers
- Per abdominal examination: lower abdominal tenderness or guarding
- Pelvic examination: Uterine/adnexal tenderness, cervical movement tenderness,

Note: A urine pregnancy test should be done in all women suspected of having PID to rule out ectopic pregnancy.

Laboratory Investigations

If available
- Wet smear examination
- Gram stain for gonorrhea
- Complete blood count and ESR
- Urine microscopy for pus cells

Differential diagnosis
- Ectopic pregnancy
- Twisted ovarian cyst
- Ovarian tumor
- Appendicitis
- Abdominal tuberculosis

Treatment (Out Client treatment)

In mild or moderate PID (in the absence of tubo ovarian abscess), outClient treatment can be given. Therapy is required to cover *Neisseria gonorrheae, Chlamydia trachomatis* and anaerobes.

- Tab. Cefixim 400 mg orally BD for 7 days + Tab. Metronidazole 400mg orally, twice daily for 14 days
  +
- Doxycycline, 100mg orally, twice a day for 2 weeks (to treat chlamydial infection)
- Tab. Ibuprofen 400mg orally, three times a day for 3-5 days
- Tab. Ranitidine 150mg orally , twice daily to prevent gastritis
- Remove intra uterine device, if present, under antibiotic cover of 24-48 hours
- Advise abstinence during the course of treatment and educate on correct and consistent use of condoms
- Observe for 3 days. If no improvement (i.e. absence of fever, reduction in abdominal tenderness, reduction in cervical movement, adnexal and uterine tenderness) or if symptoms worsen, refer for inClient treatment.

Caution: PID can be a serious condition. Refer the client to the hospital if she does not respond to treatment within 3 days and even earlier if her condition worsens.

Syndrome specific guidelines for partner management

- Treat all partners in past 2 months
- Treat male partners for urethral discharge (gonorrhea and chlamydia)
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate on correct and consistent use
- Refer for voluntary counseling and testing for HIV, Syphilis and Hepatitis B
- Inform about the complications if left untreated and sequelae
- Schedule return visit after 3 days, 7 days and 14 days to ensure compliance

Management of Pregnant Women

Though PID is rare in pregnancy,

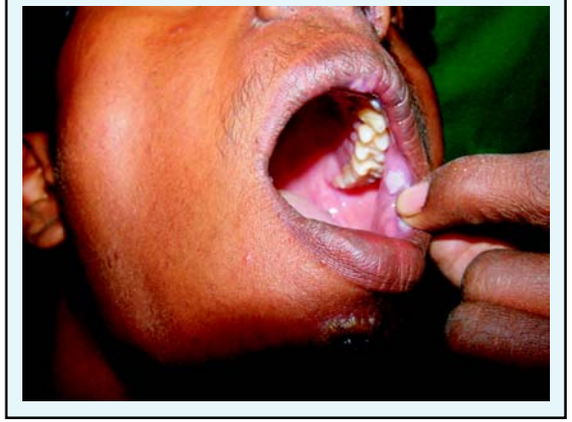
- Any pregnant woman suspected to have PID should be referred to district hospital for hospitalization and treated with a parenteral regimen which would be safe in pregnancy.
- Doxycycline is contraindicated in pregnancy.
- Note: Metronidazole is generally not recommended during the first three months of pregnancy. However, it should not be withheld for a severely acute PID, which represents an emergency

Hospitalization of clients with acute PID should be seriously considered when:

- The diagnosis is uncertain
- Surgical emergencies e.g. appendicitis or ectopic pregnancy cannot be excluded
- A pelvic abscess is suspected
- Severe illness precludes management on an outClient basis
- The woman is pregnant
- The client is unable to follow or tolerate an outClient regimen
- The client has failed to respond to outClient therapy

Note: All Clients requiring hospitalization should be referred to the district hospital

Flowchart 5.7: Management of Oral & Anal STIs



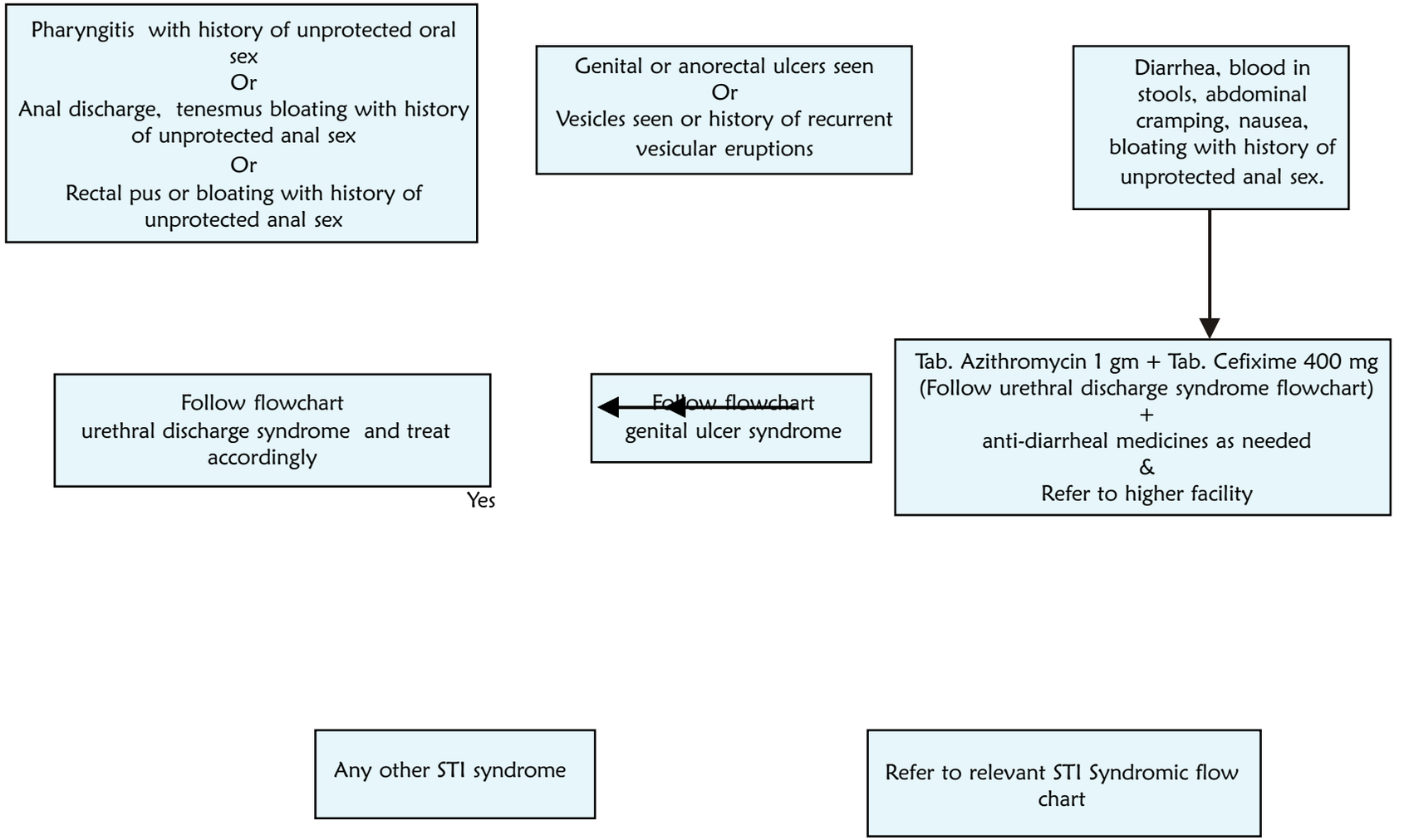
Causative Organisms
- *Neisseria gonorrhoeae*
- *Chlamydia trachomatis*
- *Treponema pallidum* (syphilis)
- *Haemophilus ducreyi* (chancroid)
- *Klebsiella granulomatis* (granuloma inguinale)
- *Herpes simplex* (genital herpes)

History of
- Unprotected oral sex with pharyngitis
- Unprotected anal sex with anal discharge or tenesmus, diarrhea, blood in stool, abdominal cramping, nausea, bloating

Examination
Look for
- Oral ulceration, redness, pharyngeal inflammation
- Genital or anorectal ulcers – single or multiple
- Presence of vesicles
- Rectal pus
- Any other STI syndrome

(Do proctoscopy for rectal examination if available)

Laboratory Investigations
- RPR/VDRL for syphilis
- Gram stain examination of rectal swab will show gram negative intracellular diplococcic in case of gonorrhea.


Pharyngitis with history of unprotected oral sex
Or
Anal discharge, tenesmus bloating with history of unprotected anal sex
Or
Rectal pus or bloating with history of unprotected anal sex
Genital or anorectal ulcers seen
Or
Vesicles seen or history of recurrent vesicular eruptions
Diarrhea, blood in stools, abdominal cramping, nausea, bloating with history of unprotected anal sex.
Tab. Azithromycin 1 gm + Tab. Cefixime 400 mg
(Follow urethral discharge syndrome flowchart)
+
anti-diarrheal medicines as needed
&
Refer to higher facility
Follow flowchart
genital ulcer syndrome
Follow flowchart
urethral discharge syndrome and treat accordingly
Yes
Any other STI syndrome
Refer to relevant STI Syndromic flow chart

Management of Anogenital warts

Fig 5 a to c: Anogenital warts

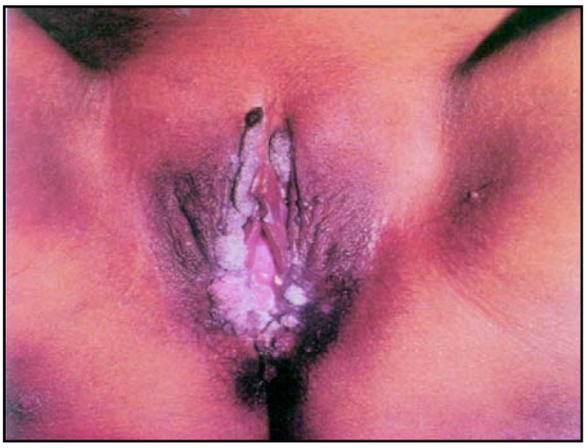


Fig 5a: Perivulval warts

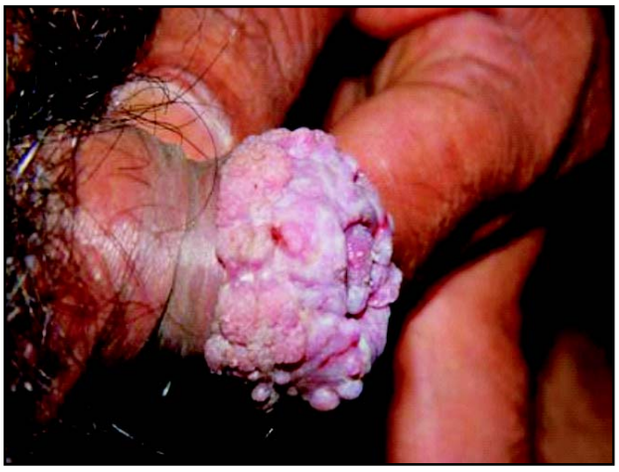


Fig 5b: Penile warts

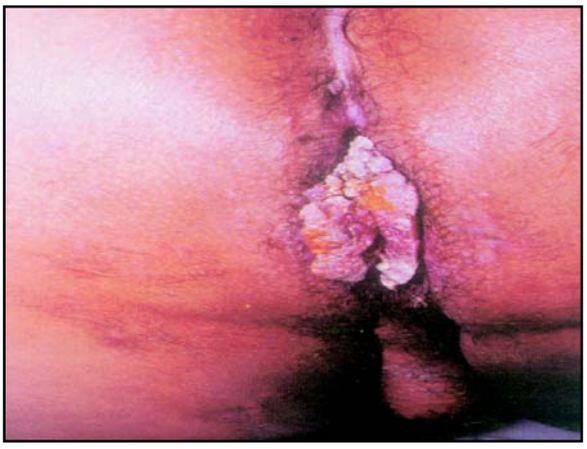


Fig 5c:Perianal warts

Management of Molluscum contagiosum and Ectoparasitic infestation

Causative Organism

Virus: Human Papilloma Virus (HPV)

Clinical features

Single or multiple soft, painless, pink in color, "cauliflower" like growths which appear around the anus, vulvo-vaginal area, penis, urethra and perineum. Warts could appear in other forms such as papules which may be keratinized.

Diagnosis

Presumptive diagnosis by history of exposure followed by signs and symptoms.

Differential diagnosis

i. Condyloma lata of syphilis

ii. Molluscum contagiousm

Treatment

Recommended regimens:

Penile and Perianal warts

- 20% Podophyllin in compound tincture of benzoin applied to the warts, while carefully protecting the surrounding area with Vaseline, to be washed off after 3 hours. It should not be used on extensive areas per session.
- Treatment should be repeated weekly till the lesions resolve completely.

Note: Podophyllin is contra-indicated in pregnancy. Treatment should be given under medical supervision. Clients should be warned against self-medication.

Cervical warts

- Podophyllin is contra-indicated.
- Biopsy of warts to rule out malignant change.
- Cryo cauterization is the treatment of choice.
- Cervical cytology should be periodically done in the sexual partner(s) of men with genital warts.

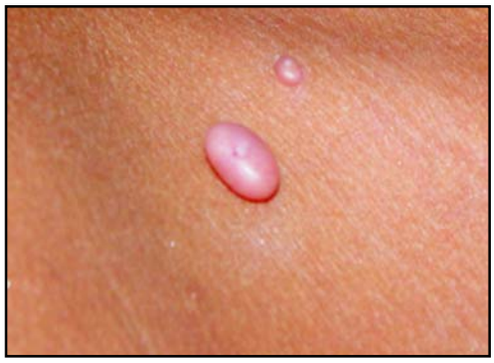


Fig 5d: Molluscum contagiosum

Causative Organism

Pox virus

Clinical features

Multiple, smooth, glistening, globular papules of varying size from a pinhead to a split pea can appear anywhere on the body. Sexually transmitted lesions on or around genitals can be seen. The lesions are not painful except when secondary infection sets in. When the lesions are squeezed, a cheesy material comes out.

Diagnosis

Diagnosis is based on the above clinical features.

Treatment

- Individual lesions usually regress without treatment in 9-12 months.
- Each lesion should be thoroughly opened with a fine needle or scalpel. The contents should be exposed and the inner wall touched with 25% phenol solution or 30% trichloracetic acid.

Pediculosis pubis

Causative Organism

Lice - Phthirus pubis

Clinical features

There may be small red papules with a tiny central clot caused by lice irritation.

General or local urticaria with skin thickening may or may not be present. Eczema and Impetigo may be present.

Treatment

Recommended regimen:

- Permethrin 1% creme rinse applied to affected areas and wash off after 10 minutes

Special instructions

- Retreatment is indicated after 7 days if lice are found or eggs observed at the hair-skin junction.
- Clothing or bed linen that may have been contaminated by the client should be washed and well dried or dry cleaned.
- Sexual partner must also be treated along the same lines.

Scabies

Causative Organism: Mite - Sarcoptes Scabiei.

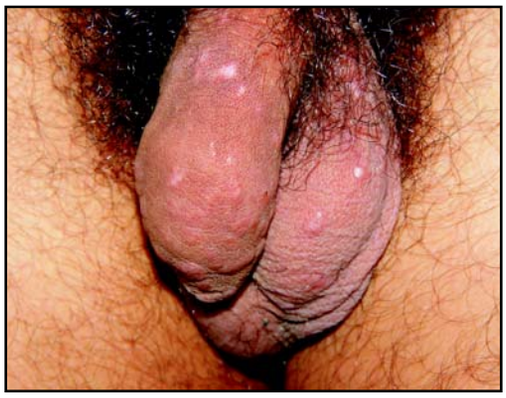


Fig 5e: Genital Scabies

Clinical features

Severe pruritis (itching) is experienced by the client, which becomes worse at night. Other members of family also affected (apart from sexual transmission to the partner, other members may get infected through contact with infected clothes, linen or towels).

Complications

- Eczematization with or without secondary infection
- Urticaria
- Glomerulonephritis
- Contact dermatitis to antiscabetic drug

Diagnosis

The burrow is the diagnostic sign. It can be seen as a slightly elevated grayish

dotted line in the skin, best seen in the soft part of the skin.

Treatment

Recommended regimens:

- Permethrin cream (5%) applied to all areas of the body from the neck down and washed off after 8—14 hours.
- Benzyl benzoate 25% lotion, to be applied all over the body, below the neck, after a bath, for two consecutive nights. Client should bathe in the morning, and have a change of clothing. Bed linen is to be disinfected.

Special instructions

- Clothing or bed linen that have been used by the client should be thoroughly washed and well dried or dry cleaned.
- Sexual partner must also be treated along the same lines at the same time.

Partner management

> Partner management is an activity in which the partners of those identified as having RTI/STI are located, informed of their potential risk of infection, and offered treatment and counseling services.

Timely partner management serves following purpose:

- Prevention of re-infection
- Prevention of transmission from infected partners and
- Help in detection of asymptomatic individuals, who do not seek treatment.

Critical issues on partner management

- Confidentiality: Partners should be assured of confidentiality. Many times partners do not seek services, as they perceive confidentiality as a serious problem. Respecting dignity of client and ensuring confidentiality will promote partner management.
- Voluntary reporting: Providers must not impose any pre-conditions giving treatment to the index client. Providers may need to counsel client several times to emphasize the importance of client initiated referral of the partners.
- Client initiated partner management: Providers should understand that because of prevailing gender inequities, women may not be in position always to communicate to their partners regarding need for partner management. Such client imitated partner management may not work in some relationships and may also put women at the risk of violence. Hence alternative approaches should be considered in such situations.

- Availability of services: RTI/STI diagnostic and treatment services should be available to all partners. This may mean finding ways to avoid long waiting times. This is important because many asymptomatic partners are reluctant to wait or pay for services when they feel healthy.

Approaches for partner management

There are two approaches to partner management:

i. Referral by index client

In this approach, index client informs the partner/s of possible infection. This appears to be a feasible approach, because it does not involve extra personnel, is inexpensive and does not require any identification of partners. A partner notification card with relevant diagnostic code should be given to each index client, where partner management is indicated. This approach may also include use of client initiated therapy for all contacts.

ii. Referral by providers

In this approach service provider contacts client's partners through issuing appropriate partner notification card. The information provided by client is used confidentially to trace and contact partners directly. This approach needs extra staff and is expensive.

Box 5.1: Coupon for a free examination

Coupon for a free examination

Date:

Please attend following centers along with the card

Stamp of the Facility

Timings:

Diagnostic Code:

Sample Partner reporting card

Note: *A two-step strategy can be used where clients are first asked to contact partners themselves. If no response till one or two weeks, clinic or health department staff can attempt to trace the contact for treatment.*

General principles for partner management

- In general, partners should be treated for the same STI as the index client, whether or not they have symptoms or signs of infection.

- Health care providers should be as sure as possible about the presence of an STI before informing and treating the partner, and should remember that other explanations are possible for most RTI symptoms like vaginal discharge.
- Special care is required in notifying partners of women with lower abdominal pain who are being treated for possible pelvic inflammatory disease. Because of the serious potential complications of PID (infertility, ectopic pregnancy), partners should be treated to prevent possible re-infection. It should be recognized, however, that the diagnosis of PID on clinical grounds is inaccurate, and the couple should be adequately counseled about this uncertainty. It is usually better to offer treatment as a precaution to preserve future fertility than to mislabel someone as having an STI when they may not have one.

Follow-up visits

Follow up visits should be advised

- To see reports of tests done for HIV, Syphilis and Hepatitis B.
- If symptoms persist, advise clients to come back for follow up after 7 days. In case of PID, follow up should be done after 2 to 3 days.

Management of treatment failure and re-infection

When clients with an RTI/STI do not respond to treatment, it is usually because of either treatment failure or re-infection. Ask the following questions to ascertain the cause:

<u>To probe for treatment failure</u>

- Did you take all your medicines as directed?
- Did you share your medicine with anyone, or stop taking medicines after feeling some improvement?
- Was treatment based on the national treatment guidelines? Also consider the possibility of drug resistance if cases of treatment failure are showing an increasing trend.

<u>To probe for re-infection</u>

- Did your partner(s) come for treatment?
- Did you use condoms or abstain from sex after starting treatment?

Note: *Recurrence is also common with endogenous vaginal infections, especially when underlying reasons (douching, vaginal drying agents, diabetes mellitus hormonal contraceptives) are not addressed.*

Box 5.2: Management of treatment failure and re-infection

For treatment failure

All cases of treatment failures should be referred to higher health facility.

For re-infection

- Consider re-treatment with same antibiotics.
- Refer to higher health facility if symptoms persist.

Screening for Asymptomatic Clients

It is well known that most RTIs/STIs are asymptomatic, especially amongst the women. The case finding is a process of opportunistic screening for an infection at the time when an individual presents to a health facility, regardless of presence of symptoms. Case findings opportunities are most commonly seen while providing services for contraception. Providers should use opportunities for potential contraceptive clients to screen for RTIs/STIs. The National Guidelines for IUD, Oral Pills, National Standards for Sterilization Services provide detailed guidelines regarding screening of RTIs/STIs.

Similar opportunities exist in pregnancy care settings. Most common screening programmes worldwide are those for detecting syphilis in pregnant women. Untreated syphilis in pregnant female is associated with number of adverse outcomes such as pregnancy loss, stillbirths and congenital syphilis. Providers are recommended to follow Government of India's following guidelines while providing services to pregnant women:

1. Guidelines for Pregnancy Care and Management of Common Obstetric Complications by Medical Officers, 2005.
2. Guidelines for Ante-Natal Care and Skilled Attendance at Birth by ANMs and LHVs, 2006.